The Mortality of Parturition.—DAVIS (*Jour. Am. Med. Assn.*, February 21, 1920, p. 523) contributes a paper upon this subject. Much of his data is obtained from applications for insurance in life insurance companies. He draws attention to the lack of suitable hospital accommodations for parturient women. He considers the midwife a menace and believes that obstetric surgery and practice should be done in the homes of patients only under the most favorable conditions. Mortality statistics show that for women of the child-bearing age, fifteen to forty-five, childbirth is the second greatest cause of death. Life insurance records show that, for all women insured under forty-five years of age, the diseases of pregnancy and of the puerperal state constitute the second greatest cause of death. Nephritis and so-called Bright's disease and childbirth occupy the fifth place as to causes of death among insured women. A study of 10,000 family histories given by applicants for insurance shows that 1 in every 17.3 associates the death of a mother or sister or both with childbirth, 1 in 28.3 with tuberculosis, 1 in 45 with cancer. It is known that a considerable percentage of these deaths are inaccurately recollected, hence these records are often not accurate in showing the frequency with which childbirth is the contributary cause of death.

GYNECOLOGY

UNDER THE CHARGE OF

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New Uterine Suspension Operation.—A review of gynecological literature for any given year would not be complete if mention were not made of at least one of the dozen or so new operations for suspension of the uterus which are thrust upon the profession every year. One of these new operations has been described by GRAD (*Am. Jour. Obst., and Gynec.*, 1921, I, 411), and consists essentially of a subperitoneal shortening of the round ligaments. He has performed several hundred of these operations during a period of eight years, and from a review of one hundred cases in which a follow-up study was made, he is convinced that his operation eclipses all its predecessors. Such a feeling, however, is rather common among inventors of operations. In brief, the technic of the operation consists of grasping the round ligament midway between its cornual insertion and the internal ring and putting the ligament on tension. Immediately below the grasp of the forceps the operator picks up the anterior layer of the broad ligament with a thumb forceps and nips it with a scissors. Beginning at this point, with the scissors, the incision in the anterior layer of the broad ligament is extended along the edge of the round ligament, until the internal

ring of the inguinal canal is reached. In this manner the entire round ligament is divested of its peritoneum and the broad ligaments are separated. A stitch of linen is then taken in the pillars of the ring, which also picks up half of the round ligament as it enters the ring, and then with the same suture the round ligament is picked up, inside of its denuded area, about one inch from its uterine end and the two points of the ligament are brought together by tying the suture. The uterine end of the ligament is then sutured to the pillars of the internal ring with a few linen sutures and the intervening redundant portion of the round ligament is sutured together and then buried between the layers of the broad ligament, all of this being accomplished with the original suture. The anterior layer of the broad ligament is then sutured with catgut to the posterior surface of the round ligament, burying the redundant round ligament and covering all raw surfaces. After the procedure is performed on both sides the operation is frequently supplemented by shortening the uterosacral ligaments or by a ventrosuspension by means of a single catgut stitch, so as to be only temporary in nature. As a result of the author's investigation into this subject he concludes that every case of retroversion of the uterus with symptoms requires an abdominal section, and for this purpose the above operation is readily performed and is not time-consuming, creates no abnormal conditions in the pelvis, tunnels no holes through the abdominal parietes, causes no intraperitoneal complications, does not interfere with pregnancy or labor, is devoid of mortality and morbidity, and the final results of the operation show 95 per cent of successes which should be a very high recommendation.

Stem Pessary.—The stem pessary is up again for discussion after a peaceful slumber for a few years. This time RAWLS (*Am. Jour. Obst. and Gynec.*, 1921, I, 499) has studied the end results in 117 cases in which a stem pessary was used for one reason or another in the Woman's Hospital of New York and has come to fairly definite conclusions. He states that the intra-uterine stem pessary has a limited field of usefulness in gynecology. It is applicable to 51.7 per cent of cases suffering from either dysmenorrhea, sterility, amenorrhea, anteflexion of the uterus, stenosis of the cervix or congenital malformation of the uterus. As an operative measure it is applicable to 2.3 per cent of patients treated and 1.3 per cent of operations performed in a gynecological ward. From its use sequelæ other than a temporary rise of temperature occur in from 17.6 per cent to 21.8 per cent of the cases, with a permanent morbidity of from 5.8 per cent to 9.8 per cent. As a therapeutic measure for dysmenorrhea there is improvement in 77.8 per cent with relief in 61.1 per cent, and for sterility there is relief in 23.4 per cent. The intra-uterine stem pessary gives as good end-results as other operative procedures for like indications, and from its use there is less primary invalidism and no more liability to sequelæ or morbidity. The stem pessary should never be used except in carefully studied and selected cases, and then the minimum of sequelæ and morbidity with the maximum of result will be obtained, as evidenced by the careful study which the author has made.